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# Entitlements

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## entitlements

Entitlements are federal government programs that require payments to any individuals or organizations eligible to receive benefits defined by law. There are many different types of entitlements, though most of the entitlement expenditures of the federal government are distributed to the most vulnerable individuals in society—the poor, disabled, and elderly. Consequently, in addition to providing a legal right to payments for eligible beneficiaries, many entitlements carry a moral obligation to those in need. Moreover, some of the most costly entitlement programs, such as SOCIAL SECURITY and Medicare, are supported in PUBLIC OPINION polls by large majorities of Americans and are bolstered by powerful INTEREST GROUPS.

Since entitlements are products of legislation, entitlement benefits can only be increased or reduced either by changing existing law or by adopting new law. Reducing entitlement benefits through legislative reforms has proven to be difficult, though there is a compelling case for cutting entitlement spending. Entitlement expenditures have been largely responsible for the long-term growth in federal government spending since the mid-1960s, and the greatest budgetary effects are yet to come. Spending projections for meeting retirement and health care obligations of

the burgeoning “baby boom” generation over the next 50 years are literally unsustainable under existing law. Ultimately, entitlement benefits will need to be reduced or additional taxes will need to be raised in order to cover the expected growth of entitlement spending.

A basic understanding of entitlements requires an introduction to the variety of entitlement programs, the development of entitlement legislation and the causes of spending growth, future projections of entitlement spending, and the challenge of entitlement reform.

Entitlement programs are typically classified as either “means tested” or “non-means tested.” Means tested programs take into account an individual’s financial need, whereas non-means tested programs distribute benefits regardless of an individual’s financial need. Means tested entitlements include such programs as Medicaid, Supplemental Security Income (SSI), food stamps, student loans, and unemployment compensation. Non-means tested programs include Social Security, Medicare, government pensions, military retirement, and veterans’ benefits.

These programs vary in terms of their size, complexity, and the constituencies they serve. The largest entitlement, in terms of both cost and number of beneficiaries, is Social Security, which provides benefits for retirees and the disabled as well as benefits for their dependents and survivors. In 2005, Social Security paid benefits totaling \$521 billion to more than 48 million people. Medicare, the health insurance program for people 65 years of age or older, is the second-largest entitlement program, covering benefits of more than 42 million people at a cost of \$333 billion in 2005. Medicaid, the health insurance program for low-income individuals, is the third most costly program; it served 44 million people at a cost of \$181.7 billion in federal expenditures. These three programs alone consumed 42 percent of all federal spending and about 71 percent of all entitlement spending in 2005.

Programs such as unemployment compensation, food stamps, government pensions, military retirement, student loans, and veterans’ benefits are geared toward smaller constituent groups. All entitlement programs contain an array of details that define eligibility and benefits, though some are more complex than others.

Several programs, including Medicaid, food stamps, and unemployment compensation, depend on contributions from STATE GOVERNMENTS.

The origins and development of entitlements are as various as the programs themselves, though they typically emerge from crises, broad public concerns, and/or the innovations of policy makers or well-organized groups. Social Security began as a modest program under the Social Security Act of 1935 during the Great Depression to provide income security to aged people who could no longer work to make a living. The Social Security Act of 1935 also created Aid to Dependent Children (ADC), later changed to Aid to Families with Dependent Children (AFDC). ADC provided cash benefits to families with children who had lost a primary income earner. Social Security benefits increased with amendments to the Social Security Act in 1950 and the addition of disability insurance in 1954.

But the largest growth in entitlement programs occurred in the 1960s and 1970s during the GREAT SOCIETY era and its aftermath. Medicare and Medicaid were created in 1965, along with several smaller programs, such as food stamps and the Guaranteed Student Loan program. From 1967 to 1972, Congress and the president (both Lyndon B. Johnson and Richard Nixon) passed several increases in Social Security retirement and family support benefits. Two major enhancements in 1972 capped off this period of program expansion: Supplemental Security Income (SSI), a program to assist poor elderly, blind, and disabled individuals, and automatic cost-of-living-adjustments (COLAs) to retiree benefits. COLAs guaranteed that retiree benefits would increase with the rate of inflation, thus ensuring that the recipients' purchasing power would not be eroded by economic forces that increased prices of goods and services.

As large deficits emerged in the 1980s and 1990s, policy makers generally stopped adding new entitlement benefits. In fact, on several occasions Congress and the president enacted legislation that reduced benefits for farm subsidies, veterans, food stamps, government pensions, Medicare, Medicaid, and even Social Security. Though many of these cuts were modest, all of them were politically difficult to enact, and some amounted to very significant policy changes. In 1996, for instance, Congress

and President Bill Clinton approved a welfare reform law that eliminated the entitlement status of AFDC and replaced it with a block grant to states entitled Temporary Assistance for Needy Families (TANF).

Despite attempts to control spending, one consequence of the program expansions of the 1960s and 1970s has been the growth of entitlement spending as a percentage of all federal spending. In order to make this point, it is helpful to identify three broad spending categories of the federal budget. First, discretionary spending refers to spending for domestic and defense programs that are subject to annual APPROPRIATIONS approved by Congress. Thus, if it wants to increase spending for homeland security, or raise the salaries of civil servants, or cut spending for after-school enrichment programs, it may do so. Literally thousands of line items for discretionary programs are adjusted annually through the appropriations process. A second category is mandatory spending, which covers entitlements. Mandatory programs are not subjected to annual appropriations; the amount spent on entitlement programs is determined by how many individuals or institutions qualify for the benefits defined by legislation. The third category is interest on the national debt; when the budget is in a deficit, the DEPARTMENT OF THE TREASURY needs to borrow money to pay the bills, and it must, of course, pay interest on that debt.

In 1964, prior to the creation of Medicare and Medicaid and the expansions of Social Security, mandatory-entitlement spending accounted for 34 percent of all federal spending; in 2005, mandatory-entitlement spending had grown to about 58 percent of all spending. Thus, while Congress cut some benefits in the 1980s and 1990s, it did not do nearly enough to halt the upward spending growth in entitlements.

The shift from a budget based primarily on discretionary programs to a budget driven by entitlements has profound implications for spending control. Since discretionary programs can be adjusted annually in the appropriations process, at least theoretically, Congress can control spending from year to year. But entitlement spending is uncontrollable so long as the law defining benefits does not change; spending for entitlements depends mainly on the number of eligible beneficiaries, the types of the benefits, and

numerous uncontrollable forces, such as the state of the economy, demographic changes in the population, and the price of health care. If the economy goes into a recession, claims for means tested entitlements—food stamps, unemployment insurance, and Medicaid—increase. If the number of retirees increases, if people live longer, or if inflation increases, expenditures for Social Security will grow.

Medicare, one of the most expensive and fastest-growing entitlements, provides a good example of the difficulties of controlling entitlement spending. Over the past 30 years, large increases in health-care costs above the rate of inflation accounted for the dramatic increases in public health programs. When health inflation rises in a given year, the president and Congress cannot simply decide to spend less. Under existing law, doctors and hospitals are entitled to be reimbursed, and beneficiaries are entitled to medical services and treatment. Total annual spending on Medicare depends on the costs of those services and the number of eligible Medicare beneficiaries who use the health-care system. Thus, in order to reduce Medicare spending, the laws specifying eligibility must be changed first, which means reducing the benefits, increasing the costs to senior citizens, or cutting reimbursements to doctors and hospitals. Though Congress and the president have made such changes from time to time, the effects on total spending are overwhelmed by the general increase in health care spending.

Thus, the rapid growth in entitlement spending began as a result of policy changes in the 1960s and early 1970s, but policy makers generally stopped adding more entitlement *benefits* by the mid-1970s. The growth in overall entitlement spending after 1974 resulted from demographic, economic, social trends, and health care cost inflation. Even though overall entitlement spending grew more than discretionary programs in the 1980s and 1990s, except for Medicare and Medicaid, it grew at a slower pace than in the 1960s and 1970s.

Entitlements are projected to grow dramatically in the future as the baby boomers retire and make unprecedented claims on retirement benefits and the public health-care system. From 2010 to 2030, the number of individuals over the age of 65 will double, and the percentage of people over the age of

65 will increase from 13 to 19 percent of the population. As a result of this demographic shift in the population, by 2030, Social Security, Medicare, Medicaid, and interest on the national debt will consume virtually every dollar of expected revenues under existing law.

The long-term budget outlook for entitlement spending was compounded in 2004, when Congress and President George W. Bush enacted the Medicare Modernization Act (Medicare Part D), which provided prescription drug coverage to Medicare-eligible individuals. As of January 2006, about 22.5 million of the 43 million Medicare recipients had enrolled in Medicare Part D, and the program is expected to cost \$558 billion over the first 10 years and will grow even more rapidly thereafter.

David Walker, comptroller general of the GOVERNMENT ACCOUNTABILITY OFFICE, has been the most recent voice among public officials who have declared the projected path of entitlement spending growth “unsustainable.” If nothing is done to slow the rate of growth in the big entitlement programs, the next generation of workers and their children will face massive tax increases, a reduction in their standard of living, or both. Entitlement reform advocates say it is economically, fiscally, and morally unacceptable to not change this course. The next generation should not be saddled by the excesses of the previous generations, especially when the problems are clear.

But the prospects for reining in entitlement spending are complicated by practical considerations, moral claims, and political forces. Despite the massive total cost to finance Social Security, the average monthly benefit is just over \$1,000 per retiree. The good news is that a small average reduction in benefits would generate massive budget savings, but the bad news is that many retirees depend on every dollar of Social Security for subsistence. Meanwhile, Medicare and Medicaid are essential programs for millions of Americans now and in the future who will need access to the health-care system. Advocates of Social Security, Medicare, and Medicaid point out that these programs have rescued tens of millions of senior citizens from a life of poverty in old age. Any cut, particularly for low-income recipients, would be a step backward in terms of addressing the needs of the elderly.

Importantly, Social Security presents a simple set of solutions compared with Medicare and Medicaid. Demands on Social Security are fairly easy to calculate, given average life expectancies and readily available demographic data, and the alternatives for cutting spending are clear enough. Increasing the retirement age, reducing the amount of benefits, and changing the way inflation adjustments are calculated are a few notable changes that could produce savings. The costs of Medicare and Medicaid, on the other hand, are tied to the costs of health care in general. Thus, while government reforms such as reducing fraud and waste and developing a more competitive pricing structure will reduce spending, the key to controlling the costs of Medicare and Medicaid is to contain health-care costs in general, a more vexing challenge for policy makers.

The political obstacles to entitlement reform are formidable. Public opinion polls repeatedly show that Americans oppose cuts in Social Security, Medicare, and, to a lesser extent, Medicaid. Support for these programs is broad and deep; there are no clear divisions across party lines or among age groups. Younger individuals are more inclined to support private accounts as a substitute for the current Social Security program, but they do not support spending cuts. Moreover, entitlements are supported by powerful interest groups. The American Association of Retired Persons (AARP), which spearheads a coalition of senior citizen groups, has over 35 million members and amounts to one of every four registered voters. More specialized groups—hospitals, nursing homes, doctors, health maintenance organizations (HMOs), insurance companies, and now drug companies—all have a stake in the outcome of policy changes. Entitlement reform is certainly possible; after all, we have examples from the past, but the political opposition should not be understated.

Thus, we are left with a complicated and challenging puzzle: How does the federal government meet its legal obligations and deliver the necessary benefits to individual recipients of popular programs and also address the inevitable imbalance of entitlement spending to projected tax revenues? Addressing the problem will require considerable leadership in order to build a consensus that balances the claims of multiple constituencies. Indeed, the lives of virtually

every American over the next 50 years will depend on the answer to this question.

See also WELFARE POLICY.

### Further Reading

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—Daniel J. Palazzolo